



Behavioral Health Agencies
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

DEEMING APPLICATION

Please complete a separate form for the main agency and for each branch.

Check the organization that accredits your agency:	
<input type="checkbox"/> <u>CARF International</u> : Current Accreditation: Effective Date _____ Expiration Date _____	
<input type="checkbox"/> <u>Council on Accreditation (COA)</u> : Current Accreditation: Effective Date _____ Expiration Date _____	
<input type="checkbox"/> <u>The Joint Commission</u> : Current Accreditation: Effective Date _____ Expiration Date _____	
Name of your agency (as printed on your agency's DOH Certificate of Approval)	
Line 1: Line 2:	
Your agency number (as found on your agency's DOH Certificate of Approval)	
Mental Health _____	Chemical Dependency _____ Problem Gambling _____
Agency Administrator:	
Name: _____	
Clinical Staff:	
Medical Director Name, if applicable: _____	DOH Credential Number _____
MH Clinical Supervisor Name: _____	DOH Credential Number _____
CD Clinical Supervisor Name: _____	DOH Credential Number _____
Facility Information:	
Street Address: _____	
City: _____	County: _____ State: _____ Zip Code: _____
Mailing Address: <input type="checkbox"/> Check if same as street address	
PO Box or Mailing Address: _____	
City: _____	State: _____ Zip Code: _____
Agency Telephone Number(s) (____) _____ <input type="checkbox"/> Check if toll-free Extension number/Additional information: _____	Fax Number: (____) _____
Agency email address: _____	Agency Website Address: _____
MATERIALS TO BE SUBMITTED WITH THIS APPLICATION	
<input type="checkbox"/> A copy of the most recent accreditation survey report and cover letter.	
<input type="checkbox"/> A copy of the current accreditation certificate issued by your accreditation body.	

<input type="checkbox"/> A copy of the agency's hiring policy and procedures.
<input type="checkbox"/> A copy of a plan of corrections, if any, required by the accreditation body.
<input type="checkbox"/> A copy of the accreditation body's approval of the plan of corrections, if any.
<input type="checkbox"/> A copy of the agency's annual declaration to the accrediting body since the last accreditation survey, if applicable.

DECLARATIONS

I am aware that as Administrator of this licensed/certified agency, I am responsible for ensuring the day-to-day operation of the agency and for all of the key responsibilities. Initials _____

I am aware that in addition to the requirements of the relevant accreditation body, my agency must meet all Washington State specific statutes (Revised Code of Washington - RCW), and administrative rules (Washington Administrative Code – WAC). Initials _____

I understand that DOH and the accrediting body communicate about DOH actions such as survey reports, complaint and/or incident investigations, corrective action plan implementation, facility reviews, and other reviews required by state licensure and certification. Initials _____

I have reviewed my organization's written policies, procedures, and practices and determined that all required policies, procedures, and practices meet the following requirements:

<u>Initials</u>	1. Administrative requirements.
	2. Clinical requirements for the provision of mental health services, if certified for those services.
	3. Clinical requirements for the provision of chemical dependency services, if certified for those services.
	4. Clinical requirements for the provision of problem and pathological gambling services, if certified for those services.
	5. All RCW and WAC that relate to the provision of DOH-licensed/certified Behavioral Health Services.
	6. If any item in this list is not initialed, a plan of correction is enclosed with projected completion dates to bring our organizational policies, procedures, and practices into compliance with the above requirements.

The information contained in this declaration and on all supporting documents submitted in support of this declaration is true, accurate, and complete to the best of my knowledge.

Signature of Administrator	Date
Type or Print Name	Title
Address	Telephone (____) _____
	E-mail